



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

PINE CREEK MEDICAL CENTER

Respondent Name

MERGED SAFEGUARD INSURANCE COMPANY

MFDR Tracking Number

M4-18-0215-01

Carrier's Austin Representative

Box Number 11

MFDR Date Received

September 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The treatment that was rendered was to confirm that the patient is continuing to take his medication. I am seeking assistance in getting this claim paid."

Amount in Dispute: \$250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The disputed service is a repeat urine drug screen, DOS 12/8/16. By an Adverse Determination upon Retrospective Review dated 05/03/16, the Provider was notified that the Carrier believed that, under the facts reflected in the medical records, repeated urine drug screens were not medically necessary and were services that exceeded the limitations of the ODG."

Response Submitted by: Flahive, Ogden & Latson, Attorneys at Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 8, 2016	Outpatient Hospital – Qualitative, Presumptive, Drug Screening: 80301, G0477	\$250.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.3 sets rules for communication between providers and insurance carriers.
4. 28 Texas Administrative Code §133.240 sets out requirements for paying or denying medical bills.
5. 28 Texas Administrative Code §133.500 sets standards and formats for electronic medical bill processing.
6. 28 Texas Administrative Code §133.501 sets out requirements for electronic medical bill processing.
7. 28 Texas Administrative Code §19.2009 sets out rules for notices of determinations made in utilization review.
8. 28 Texas Administrative Code §19.2010 sets out requirements prior to issuing an adverse determination.

9. Insurance Code Chapter 4201 sets out provisions regarding utilization review of health care services.
10. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 181: OC – Procedure code was invalid on the date of service.
 - OC (181) – This procedure is not a valid fee schedule service.
 - 16: 28 – Claim/service lacks information which needed for adjudication.
 - 28 (16) – The reduction was made for reasons indicated in note below or on the attached note or letter.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Are there any outstanding issues of medical necessity?
3. Did the respondent raise new issues or defenses in their position statement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 16: 28 – "Claim/service lacks information which needed for adjudication"; and 28 (16) – The reduction was made for reasons indicated in note below or on the attached note or letter."

Nowhere on the explanation of benefits (EOB) does the insurance carrier detail or explain what information was lacking that was needed for adjudication. Neither does the respondent discuss or explain in their position statement what information was lacking that was needed for adjudication. This denial reason is not supported.

2. The division notes that nowhere on the EOB(s) did the carrier make reference to adjustment codes or denial reasons related to medical necessity or authorization. However, the respondent's position statement asserts:

By an Adverse Determination upon Retrospective Review dated 05/03/16, the Provider was notified that the Carrier believed that, under the facts reflected in the medical records, repeated urine drug screens were not medically necessary and were services that exceeded the limitations of the ODG.

Although the attached letter purports to be a retrospective review of medical services, it is dated May 3, 2016. That letter further lists file contents reviewed of medical records that are all dated from 2015. The disputed services were performed on December 8, 2016 — some seven months after the alleged "retrospective" review. As the respondent did not present any documentation to support time travel, the division is not persuaded that the disputed services were retrospectively reviewed on May 3rd — as the services had not yet been rendered.

Given that the EOBs do not list any denial codes related to medical necessity or authorization, and as the attached letter references services that were not related to the disputed medical bill, the division finds the respondent has not supported their assertion that "the Provider was notified that the Carrier believed that, under the facts reflected in the medical records, repeated urine drug screens were not medically necessary. . ."

In fact, the respondent's documentation does not support a retrospective review was ever performed on the disputed services (rendered on December 8, 2016). The division finds the "facts reflected in the medical records" of December 8th were not examined by a qualified utilization review agent certified under Insurance Code Chapter 4201; the letter is not related to the date of service. Nor is it evidence of a determination against disputed services.

Moreover, no evidence was presented that any adverse determination was issued in regard to the disputed services of December 8th in accordance with the requirements of 28 Texas Administrative Code §19.2009 (regarding notice of utilization review determinations), §19.2010 (relating to requirements prior to issuing adverse determination), or §134.240 (regarding medical payments and denials).

Accordingly, the division finds that the respondent has not asserted a medical necessity dispute regarding the services of December 8, 2016, and no unresolved medical necessity issues are outstanding. The division will therefore consider the disputed fee issues according to applicable division rules and fee guidelines.

3. The respondent's position statement raises new denial reasons or defenses in regard to the disputed services that were not presented to the health care provider prior to the filing of the medical fee dispute request.

Rule §133.307(d)(2)(F) requires that:

The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

Rules §133.240 (e) and (e)(1) require that when paying, reducing or denying payment on a medical bill, the insurance carrier shall send to the health care provider an explanation of benefits in accordance with the elements required by Rules §133.500 and §133.501.

Rule §133.3(a) requires that:

any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "insurance carrier improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section.

Respondents are limited at Medical Fee Dispute Resolution to arguing those denial reasons the carrier has presented to the health care provider prior to the request for MFDR. The division looks to those reasons given on the explanations of benefits (by code under the appropriate ASC X12N 837 code set, as specified in the elements required by Rule §133.500) as evidence of the specific issues raised. Failure to raise specific denial reasons during the medical bill review process or reconsideration are grounds for the division to find a waiver of such defenses at MFDR. Accordingly, any newly raised denial reasons or defenses shall not be considered in this review.

4. This dispute regards outpatient hospital diagnostic laboratory services with payment subject to 28 Texas Administrative Code §134.403(f), which requires that the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, applying the effective Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from <http://www.cms.gov>.

Rule §134.403(d) requires that for coding, billing, reporting, and reimbursement of health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified by division rules.

Applying the Medicare payment policies, formulas and factors effective for the date of service, reimbursement for the disputed services is calculated as follows:

- HCPCS code G0477 has status indicator Q4, denoting packaged labs; reimbursement is bundled into other services performed the same date and is included in the payment for services billed under procedure code 80301, billed on the same claim. The use of a modifier is not appropriate. Separate payment is not recommended.
- CPT code 80301 has Medicare payment policy status indicator B, denoting codes not paid under OPPS. This code is not available for use on an outpatient facility bill (type 12x and 13x). Beginning in 2016, Medicare payment policies require qualitative drug screenings to be billed using different HCPCS codes from CPT 80301, used here. As the services were not billed in accordance with Medicare payment policies or the requirements of Rule §134.403(d), payment cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	Grayson Richardson	October 20, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim. The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.